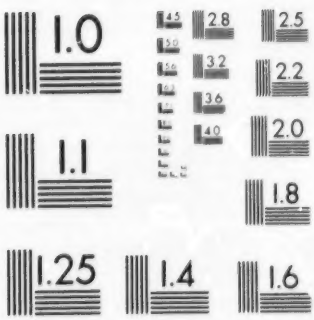

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ABSTRACT

Church-based programs for caregivers of black elders have emerged from both demographic and cultural factors. To investigate the effectiveness of a training program for caregivers of noninstitutionalized elders, 95 Washington, D.C. adults (99% black, 87% female), who were providing caregiving assistance to an older adult, completed a 12-hour training program. The program was adapted from "As Parents Grow Older: A Manual for Program Replication" (Silverman, et. al., 1981). Subjects also participated in mutual help group meetings. Participants were drawn from eight church sites, with three neighboring churches participating at one site. Two comparison sites received training after the post-test interviews. All subjects and 49 care recipients completed pre- and post-test interviews assessing caregiver behaviors and attitudes. An analysis of the results showed that, in general, persons who completed the training program did not increase the scope of their caregiving activities or improve their attitudes over time. However, given the pretraining nature of the population (low stress, positive attitudes) this finding was expected. The mutual help groups appeared to be the most successful part of the project. Enthusiasm, commitment, and the ability of the church leaders to organize and motivate church members were important factors in predicting the success of the groups. The three-church cluster was most successful in initiating multiple projects. Future research should focus on the characteristics and organizational frameworks of mutual help groups, and linkages between informal caregivers and formal service providers. (BL)

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Church-Based Programs for Caregivers of Non-Institutionalized Elders

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Introduction

Caregiving for Non-Institutionalized Black Elders

As a population, Americans continue to grow older. The percentage of Americans over age 65 has tripled during this century, from 4% of the population at the turn of the century to 11% by 1980. The projection for the age segment 65 and over for the year 2020, when the baby boom cohort of 1950 becomes the gerontology boom cohort, is up to 20% of the population.

However, even more dramatic than the aging of Americans will be the 'aging of the aged.' For instance, while 1% of Americans today are age 85 and over, 4% will join the ranks of the very old by the year 2020 (Barrow and Smith, 1983). This growth is accompanied by a startling increase in vulnerability, including physical and mental frailty, as well as dependence on long term care institutions, or family caregivers in the community.

The option of long term care institutions, however, is limited for black families. For example, while blacks constitute 11% of the national population, only 6% of all older persons residing in nursing homes are non-white (Soldo, 1977). The likely factors contributing to this inequity include institutional discrimination (Butler, 1975), shorter longevity (Jackson, 1980), and differences in the number of children who can share the caregiving burden (Soldo and DeVita, 1978). In this last regard, 35% of older, ever-married blacks had given birth to four or more children in 1970, compared to 27% of white older females.

Perhaps due to more reliance on family caregivers in the community, black elders have higher expectations toward family responsibility to older persons than do older whites (Seelbach and Sauer, 1977). It appears, however, that both expectations and actual responsibility for caring for the old are associated

with low morale. Seelbach and Sauer (1977), for instance, report a correlation between expectation of filial responsibility and low morale, particularly among black families. Similarly, a five year longitudinal study by Robinson and Thurnher (1979) concludes that the actual responsibility of caring for older parents by their families is associated with low morale.

The Black Church as a Site for Program Intervention

During the 1970's there was a surge in religiosity that cut across all sectors of the American population, though the religiosity of black Americans continued to be stronger than it was for Americans in general (Gallup, 1977). Proportionately, more blacks were members of churches and attendance rates were higher.

Furthermore, census counts have underestimated the number of black church members. For instance, a higher percentage of black church members attend small, evangelical, storefront churches like the Spiritualist and Pentecostal churches, or Muslim sects, which typically go uncounted. Also, a number of blacks, particularly those in the Catholic denomination, go uncounted because of their existing membership in white churches.

Some social analysts suggest that racial discrimination is a distinguishing factor in the intensity of the religious behavior of black church members (Dancy, 1977). Blacks are under-represented in professional organizations, social clubs and other alternative sources of recognition and emotional satisfaction. Instead, the black church takes on many of the social functions that are performed by a variety of non-religious organizations in the white community.

Another reason that blacks turn to the church is the need for social services that are perceived to be unavailable through service agencies or philanthropic

organizations. These organizations are frequently large, bureacratic in structure, and located outside of the minority neighborhood. In contrast, the life space of the low-income minority family is rooted in the narrow locale of neighborhood, which typically includes the neighborhood church.

Historically, the black church plays an important role in strengthening the family and providing social services. Dancy, with a focus on the black elder, notes:

> A strong orientation toward religion and the black church is a cultural attribute which holds a great deal of importance in the lives of the black elderly .... The church is a channel through which a large segment of the black elderly can be reached .... When vital social services were not available to its parishioners, the black church provided the needed counsel, the services, the framework of meaning (1977).

An empirical study by Cantor and Mayer (1978) lends further support to the importance of the church for the older person:

> Religious institutions, according to the study data, play an important part in the lives of many inner city elderly, particularly black and Spanish respondents. It is not unexpected, therefore, that the third most frequently turned to source of assistance was religious leaders.

Another study by Cantor (1975) reports that attending church together is one of three activities that are most likely to engage older persons in socialization, including the older caregiver who needs respite from caring for a frail spouse. In fact, while organizational membership is very low for the inner city elderly, the highest proportion of membership by far (20%) is with elderly in a church or synagogue group (Cantor, 1978).

During the past half century, the social service orientation of the black church has grown stronger. Congregation members are less frequently oriented exclusively to other-worldly exhortation and emotional catharsis. Conversely, the Martin Luther King era produced increasing attention to social action and

social justice. Since the early 1970's a growing number of black churches have begun to emphasize social service programs as part of their organizational mandate (Lincoln, 1974; Rathbone-McCuan and Hashimi, 1982).

Mutual Help Groups

The mutual help group idea began at least as far back as the mutual aid societies in the black churches in the 1700's. These societies were precursors to the modern version of a mutual help group. The first society was organized in 1787 in Philadelphia and was called the Free African Society. The purpose of this church-affiliated help group was to provide mutual assistance in times of sickness and other critical need. By the late 1800's there were nine mutual aid societies in Atlanta alone, and 6 were connected with churches (Frazier and Lincoln, 1974).

The modern prototype of a mutual help group is probably the Alcoholics Anonymous organization which began in the mid-1930's. This group, and the ones to follow, were created because of the lack of available professional or governmental assistance, and the inadequacy of existing informal help networks. In addition, the mutual help group is unique in its ability to create a personal, intimate, face-to-face atmosphere where persons of similar interest and experience can exchange ideas and coping techniques. Professional expertise, while it is obtained as needed, is secondary to the leadership of the lay membership.

It is now estimated that there are a half million mutual help groups in America, representing more than 15 million persons. The groups represent a tremendous array of interests, including nearly every disease category listed by the World Health Organization (Katz and Bender, 1976; Gartner and Riessman,

1977). Mutual help groups now provide more continuous care for chronic disease and disabilities than all the professional resources currently available in this country.

The application of mutual help groups to the needs of caregivers and non-institutionalized elders has been noted by Haber (1983). In the specific area of caregiving for older adults, the number of mutual help groups has been growing rapidly. For instance, in the New Jersey Self-Help Sourcebook (1983) the following organizations have been listed: Caregivers for the Aging, Living-room (Support for Relatives of the Elderly), Women with Aging Parents, Children of Aging Parents, Adult Children with Aging Parents, SHARE (Self-Help for Adults with Relatives who are Elderly, CAP (Caretakers of Aging Parents), etc.

Church-Based Programs: Training Program and Mutual Help Group

The 12-hour training program implemented by the Institute of Gerontology at the University of the District of Columbia is designed to introduce a variety of useful topics to church members who care for non-institutionalized elders. The training manual is adapted from the manual developed at the Institute of Gerontology at the University of Michigan-Wayne State University, entitled, As Parents Grow Older: A Manual for Program Replication (Silverman, et. al., 1981). The content of this manual has been restructured into seven topics, with each of the first six topics presented in one and a half hour classes, and the final topic in a three hour class. The seven topics are as follows:

1. Understanding the Psychological Aspects of Aging
2. Sensory Deprivation
3. Chronic Illnesses and Behavioral Changes with Age
4. Basic Nursing Care Skills for Care of the Patient at Home
5. Improving Communication
6. Living Arrangements and Shared Decision Making
7. Availability and Utilization of Community Resources

The idea of creating a mutual help group for caregivers is fostered throughout the 12-hour training program. Trainees are made aware of the tremendous flexibility of a mutual help group. For instance, existing church clubs can take on a new objective that includes a mutual help group for caregivers; or a new group can get started. Also, the functions of a mutual help group can be focused on one or more directions. For example, some groups emphasize meeting on an ongoing, regularly scheduled basis to share ideas, support and techniques of interest to elders in need and/or their caregivers. Some groups may implement a newsletter to provide useful information on caregiving or gerontological topics. Yet other groups may periodically invite outside experts to conduct seminars on topics of particular interest to church members. Finally, mutual help group members can be trained to use a comprehensive Resource Directory in order to make services and resources in the community available to all church members in need.

Whatever direction a mutual help group takes, its fundamental purpose is to continue the educational and resource-sharing goals of the training program, without dependency on professionals or funding agencies.

Method

Sample

Eight church sites from the District of Columbia were selected (with three neighboring churches participating at one church site) with three ojectives guiding the selection process:

1) to represent the percentage of black churches within each of the major denominations in America,

2) to reflect as much diversity as the inner city of the District of Columbia

will allow, in terms of income and educational level, size of congregation, percentage of membership who are elderly, and amount of church involvement with social services, and

3) to select churches with enthusiastic pastors and church leaders.

Thus, we selected three Baptist church sites, one African Methodist, one Methodist and one Episcopal site, plus two comparison sites which were Baptist. The comparison sites received the training program after the posttest interviews were completed.

Two hundred and eighty-two trainees graduated from the caregiving training programs, with 95 completing pretest and posttest interviews. Since the rapport with church members took precedence over the generalizability of the findings, we did not sample the 34% of the trainees who completed the interviews. Instead, we interviewed only those persons who volunteered to do the two interviews, and were willing to complete them at a selected church site during a designated interview period. Sixty-one respondents completed the training program prior to the posttest interview, with 25 (41%) participating in at least one mutual help group meeting. Thirty-four respondents attended the comparison churches, and completed the training program after the posttest interview.

Of the 95 respondents, 99% were black and 87% female. The mean age was 56 years, with 50% retirees. Respondents were mostly lower income, very religious, and all could identify at least one person to whom they provided caregiving assistance. Any person who provided any type of self-defined caregiving assistance was eligible for the caregiving program.

Among the care recipients who received assistance from the caregiving respondents, 49 completed pretest and post-test interviews. The average age of

the care recipients was 74 years, with a mean annual income of $5,000. Respondents were primarily black females with less than a high school education. The majority of the respondents were widowed, but only 14% lived alone. Care recipients were mainly retirees on social security. Half retired from service work, either maid or janitorial work, while 13% were retired professionals.

Administration of Instruments

The measurement instrument used for the interviews with caregivers was an amalgam of several existing instruments to assess caregiving behaviors and attitudes. One of these instruments, the OARS (Duke University, 1978), was the primary instrument administered to the care recipients as well.

The pretest interviews were conducted in March-April, 1982, and the posttest interviews in September-October, 1982. The original intent was to assess the impact of the 12-hour caregiving training program and the subsequent mutual help group meetings. However, organizational activities at the participating churches during the summer months of June, July and August were suspended until the Fall. Thus, on the average, the trainees who had joined mutual help groups were only able to attend two mutual help group meetings prior to the posttest interview.

Consequently, two separate sections for results will be reported: 1) the findings of the pretest and posttest interviews, which basically assess the impact of the training program and 2) a documentation of the mutual help group activities after one year of existence.

Results of the Caregiving Training Program

Hypothesis One: Treatment caregivers will increase the quantity of caregiving activities in comparison to control caregivers.

The following caregiving activities were provided by at least one-third of the caregiving respondents: companionship (56%), transportation (49%), continual supervision or checking (47%), homemaker/household help (38%) and assistance with crime or safety precautions (34%). At the time of the post-test interview there was little change in the priority of caregiving activities noted above, nor were new caregiving activities undertaken. Among the 61 trainee-respondents there were only three reported instances of linkages with formal agency providers that were a result of information gained from the training program. (Table 1 about here).

From a testimonial perspective, there were 88 separate comments on how the training program, the first few mutual help group meetings or the interview itself led to more efficient caregiving activity, or more effort at caregiving activity. However, there were no objective or quantitative measures to verify these testimonials.

Hypothesis Two: Treatment caregivers will have more positive attitudes toward caregiving in comparison to control caregivers.

The life satisfaction index, the caregiving satisfaction index, and the questionnaire items on intergenerational living, governmental versus family responsibility for the health needs of older persons, and attitudes toward placing an older relative in a nursing home were unchanged over time. This consistency over time was due to the unexpectedly positive attitudes reported during the pretest, with 85% of the caregivers reporting that their caregiving activities involved no sacrifice whatsoever, or a minor sacrifice.

Hypothesis Three: Treatment care recipients will improve physical/mental capacities and social resources in comparison to control care recipients.

The five rating scales of the OARS instrument: social resources, economic resources, mental health, physical health and activities of daily living,

as well as the cumulative impairment score for all five scales, remained consistent over time for both treatment and control care recipients. Also, care recipients in general reported that they received the same amount of caregiving assistance, and they received help from the same number of caregivers over time.

Results of the Mutual Help Groups

At the six treatment church sites, half were successful with sustaining a mutual help group over one year, with only occasional consultation from staff of the Institute of Gerontology at the University of the District of Columbia. Two of these churches had the highest socio-economic status levels, and one church (actually the cluster of three churches that met at one church site) had the lowest socio-economic status level. The following new caregiving activities were initiated by the three mutual help groups, with the cluster initiating the most activities:

1) A Senior Watch program to make sure that homes are not lost through unpaid taxes, utilities, etc.

2) Newsletters related to gerontological or caregiving activities.

3) Lectures on wills and pre-paid funeral arrangements, with efforts to make sure that all church members are prepared for the event of death.

4) Fund-raisers to support church projects, i.e., the mutual help group newsletters, a ramp for seniors and the handicapped, etc.

5) Lectures on issues of concern, such as housing for seniors, transportation, community services and resources, etc.

6) A resource directory for all church members, with designated members who coordinate its use, and update it.

7) Health screenings organized at the church sites.

Discussion and Conclusions

In general, persons who completed the training program did not increase the scope of their caregiving activities, nor improve their attitudes over time. This result was not surprising given the sample of respondents who were not burdened by their caregiving role at the time of the pretests. Furthermore, the inability to establish the mutual help groups prior to the posttest interviews eliminated from analysis a potentially powerful influence on caregiving behaviors and attitudes.

The consistency of physical and mental capacities and social resources of the care recipients were also affected by the same factors. There did not seem to be a substantial amount of stress in the caregiver-care receiving relationship at the time of the pretest interview, and a brief, 12-hour training program is not a particularly powerful vehicle for changing years of established behaviors and attitudes.

The most successful part of the project appeared to be the mutual help groups, and yet only half the groups were able to sustain regularly scheduled activities for more than a year after the professional leadership had left the church site. The most important factor for implementing and sustaining a mutual help group was the enthusiasm, committment and ability of the pastor and/or church leaders to organize and motivate church members. At the three church sites where mutual help groups were not initiated or sustained, the initial enthusiasm of the church pastor or deaconesses quickly waned.

In terms of predicting the success of the mutual help groups, no factor other than leadership appeared to be relevant. The three successful church

sites were not homogeneous in terms of denomination, size of church membership, history of social service activity, percentage of membership that is elderly, and socio-economic status. Conversely, at all three church sites that were successful at implementing mutual help groups, the church pastors remained involved with the caregiving activities, the deaconesses continued their enthusiastic support, and at least one church member kept in contact with a staff member at the Institute of Gerontology to discuss concerns and recent accomplishments.

In brief, the project findings stimulated several conclusions with implications for program administrators and policy-makers:

1) The mutual help groups were successful with initiating multiple projects, involving hundreds of church members. Future research efforts should focus on this aspect of intervention, with less attention to the impact of a short-term training program, except as it relates to fostering the emergence of a mutual help group.

2) The investigation of mutual help groups will be difficult, given the over-reliance on testimonials in the past, and the scarcity of objective and quantifiable efforts. Future studies should consider why caregivers do, or do not, join a mutual help group; the type of community site which fosters the emergence of a group; short-term and long-term assessments; control groups; triangulated assessment techniques like observation, interview, questionnaire and/or informants; and the impact of the mutual help group on the care recipients as well as the caregiving participants.

3) The most successful mutual help group in terms of the number of projects it initiated, involved the cluster of three churches operating at a single

community site. This type of cooperation, or friendly competition, among churches may spur greater accomplishments than would occur with one church at its own site. Further exploration is needed on caregiving programs that are based on organizational frameworks that are ecumenical, interfaith, or a cluster of churches within a single denomination.

4) This project was one of the few studies of caregiving to focus on a non-service-agency-utilizing population (Horowitz and Dobrof, 1982). While it is important for some studies to examine caregiving families before they reach a service agency, it might be more productive to target families that are experiencing a sense of caregiving burden or sacrifice, in contrast to this study's sample population.

5) The training program was not successful with fostering new caregiving activities, nor linkages with formal service providers, except on a very limited basis. As the 'aging of the aged' continues, more alternatives need to be explored for linking informal caregivers who are not willing to join a mutual help group to formal service providers.

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Table 1.

Percentage of Caregivers engaged in Specific Services

Type of Service		pretest	posttest	difference
homemaker	treatment	38	40	+2
	control	22	18	-2
employment	treatment	2	2	0
	control	1	2	+1
transportation	treatment	49	47	-2
	control	20	19	-1
home repairs	treatment	20	18	-2
	control	9	10	+1
social/recreational programs	treatment	18	16	-2
	control	7	4	-3
contact agencies	treatment	14	14	0
	control	6	7	+1
personal care	treatment	16	20	+4
	control	13	10	-3
nursing capacity	treatment	14	14	0
	control	14	9	-5
physical therapy/exercise	treatment	17	13	-4
	control	9	6	-3
counseling	treatment	17	17	0
	control	8	6	-2
financial/legal advice	treatment	26	26	0
	control	18	18	0
companionship	treatment	56	62	+6
	control	30	28	-2
crime or safety precautions	treatment	34	22	-12
	control	14	15	+1
reduced rates	treatment	17	17	0
	control	6	8	+2
meals at home/nutrition site	treatment	14	17	+3
	control	7	7	0
continual checking	treatment	47	46	-1
	control	25	23	-2
relocation	treatment	1	4	+3
	control	2	2	0
other	treatment	2	8	+6
	control	2	4	+2